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(d) intermediate services; and
(e) related medical services, including medical evaluation for admission into methadone treatment, intake physical for nonmethadone recipient, methadone treatment plan review, medication management, medication dispensing, and urinalysis and detoxification services.

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.
For family and client support services see Mental Health Rehabilitation Services.

Transportation Services

Nonemergency ground ambulance service within the same community is payable at the lesser of the amount billed the general public or the state maximum of $200 per one-way trip. Nonemergency ground ambulance service outside the community and nonemergency air ambulance service is payable at the amount billed to the general public. Prior authorization is required.

Emergency ground ambulance or commercial airline service is payable at the amount billed the general public. Emergency air ambulance service is payable at the lesser of the amount billed the general public or the state maximum allowable.

Transportation costs for an escort is payable at the amount billed the general public; prior authorization is required.

Lodging and meal costs for recipients and approved escorts are reimbursed at the lesser of the amount billed the general public or the state maximum of $79 per day for lodging, or $48 per day per person for double occupancy, and $36 per day, per person for food. Lodging and meals in a prematernal home are payable at the lesser of the amount billed or the state maximum allowable all-inclusive rate of $72 per day.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Vision Care Services

Reimbursement is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. The state awards a competitive-bid contract for eyeglasses.

7 AAC 43.100. BASIS OF PAYMENT. (a) The division will pay for medical and other health care services furnished by physicians on the basis of the reasonable charge for covered services. The reasonable charge is the lowest of the actual, usual, or customary charge, except for physicians acting as surgical assistants reimbursed under 7 AAC 42.110. If a usual charge has not been established, the reasonable charge is the lower of the actual or customary charge. If a customary charge has not been established, the reasonable charge is the lower of the actual or the prevailing charge as determined under 7 AAC 43.103.

(b) The division will, in its discretion determine the amount of the reasonable charge for covered services based on factual data on the charges made by physicians generally and on special factors that may exist in individual cases.

(c) Reimbursement for services rendered between January 1, 1991 and June 30, 1994 will be based on an analysis of reasonable charges for covered services accepted for payment by the division between July 1, 1989 and September 30, 1990. For services rendered on or after July 1, 1994, reimbursement will be:

(1) based on reasonable charges for covered services, determined after July 1 of each year from those bills the division has paid before July 1 which were for services rendered at any time during the 15-month period between April 1 of the preceding year and June 30 of the current year, adjusted according to the results of (A) and (B) of this paragraph:

(A) after July 1 of each year, the division will compute the average percentage of change between the reasonable charges of the 15-month computation period and the reasonable charges for the same services of the preceding computation period and will include that percentage adjustment in its budget request to the commissioner of the Department of Health and Social Services;

(B) the percentage adjustment for price appropriated for the non-institutional services price increase for the subsequent state fiscal year will be the maximum percentage of change that the division will apply to both the customary and the prevailing charges for services rendered and paid during that fiscal year; and

(2) applied throughout the state fiscal year.

(d) The division will not establish a usual, customary, or prevailing charge for a particular service code until the division has accepted for payment a minimum of three bills for that service code;

(e) For a hospital-based physician, the division will pay only for the services listed and the amount of compensation, as described in 7 AAC 43.107. (Eff. 8/18/79, Register 71; am 6/30/84, Register 90; am 7/1/86, Register 99; am 1/1/91, Register 117; am 10/21/92, Register 124; am 11/18/93, Register 128)

Authority: AS 47.05.010
AS 47.07.030
AS 47.07.050

7 AAC 43.101. USUAL CHARGE. (a) The usual charge is the 75th percentile of the range of charges made to the division by the physician for a specific service code during the 15-month computation period established in 7 AAC 43.100(c)(1).

(b) The division will compute the usual charge as described in 7 AAC 43.100.

(c) The division will, in its discretion, exclude from the determination of the usual charge any charges that it finds to be token or substandard.

(d) The usual charge may vary among physicians. (Eff. 6/30/84, Register 90; am 7/1/85, Register 95; am 7/1/86, Register 99; am 1/1/91, Register 117)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

7 AAC 43.102. CUSTOMARY CHARGE. (a) The customary charge in a region of the state is the 75th percentile of the range of charges made to the division by physicians in that region for similar service codes during the 15-month computation period established in 7 AAC 43.100(c)(1).

(b) The division will compute the customary charge as described in 7 AAC 43.100.

(c) Repealed 7/1/86.

(Eff. 6/30/84, Register 90; am 7/1/85, Register 95; am 7/1/86, Register 99; am 1/1/91, Register 117)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

7 AAC 43.103. PREVAILING CHARGE. (a) The prevailing charge is the 75th percentile of the charges made to the division by physicians in the state for similar service codes during the 15-month computation period established in 7 AAC 43.100(c)(1).

(b) The division will compute the prevailing charge as described in 7 AAC 43.100.

(c) If there are insufficient billings under 7 AAC 43.100(d) to establish a prevailing charge for a service, the division will reimburse the physician at 100 percent of the amount billed for that service.

(d) At the discretion of the division, but no more frequently than quarterly and no less frequently than annually, the division will review each service for which it is reimbursing 100 percent of the amount billed and establish a statewide reimbursement rate for the service as follows:

(1) if three or more billings have been accepted for the service, the division will compute the usual, prevailing, or customary charge under 7 AAC 43.100 — 7 AAC 43.103; or,

(2) if fewer than three billings have been accepted for the service, the division will establish a temporary prevailing charge by multiplying the State of Washington Department of Social and Health Services medicaid program maximum allowance, as published in the current edition of the *Schedule of Maximum Allowances and Program Descriptions*, by 3.463, and multiply the

result by 90; the temporary prevailing charge will remain in effect until the next regular computation made under 7 AAC 43.100. (Eff. 6/30/84, Register 90; am 7/1/85, Register 95; am 7/1/86, Register 99; am 1/1/91, Register 117)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

Editor's notes. — The State of Washington Department of Social and Health Services *Schedule of Maximum Allowances and Program Descriptions* is available for inspection at the Division of Medical Assistance, Building M, 4433 Business Park Blvd., Anchorage, Alaska 99503.

7 AAC 43.104. CHARGES HIGHER THAN USUAL, CUSTOMARY, OR PREVAILING. The division will, in its discretion, find reasonable a charge that exceeds (1) the usual charge of the physician who rendered the medical or other health service, (2) the customary charge in the region, or (3) the prevailing charge in the state, but only when there are unusual circumstances or medical complications requiring additional time, effort, or expense that support an additional charge, and only if it is acceptable medical practice in the state to make an extra charge in such cases. The mere fact that the physician's usual charge is higher than the customary or prevailing charge will not justify a determination that it is reasonable. (Eff. 6/30/84, Register 90)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.105. CONCOMITANT CARE. An office, hospital, or home visit fee is payable to the physician assuming major responsibility for a case. In unusual cases, where there is a need for more than one attending physician, authority for payment for concomitant care may be authorized by the division upon submittal of a Request for Authorization form. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.107. HOSPITAL-BASED PHYSICIANS. (a) Reimbursement by the division under this section for the services provided by a hospital-based physician is subject to the following limitations:

(1) reimbursable services shall include the following services furnished directly to individual patients: clinic services; outpatient services; anatomical pathology services; consultive pathology services; physician administered laboratory tests; anesthesiology services; radiology services which are separately identifiable for billing purposes; and diagnostic or therapeutic services which are

direct and discrete, such as interpretation of x-rays, angiograms, myleograms, pyelograms, or ultrasound procedures;

(2) reimbursable services must be personally furnished by the physician, contribute directly to the diagnosis or treatment of the individual patient, and ordinarily require the action of a physician;

(3) the division will not reimburse the physician for services provided by the physician to the hospital; costs incurred by the hospital for space, overhead, supplies, and equipment; and services provided to patients by non-physician personnel;

(4) the division will not reimburse for costs attributable to the time the physician spends performing hospital administrative duties, supervising professional or technical personnel, or performing other hospital-wide activities that are not covered physician services under this section.

(b) Services furnished under this section by a hospital-based physician will be reimbursed the lower of billed charges or 70 percent of the prevailing rate at time of service as established under 7 AAC 43.103 for that service. Laboratory or pathology services provided by a hospital-based physician for which a medicare fee schedule has been established in 42 C.F.R. 405.515 will be paid for according to the methodology in 7 AAC 43.125.

(c) For purposes of this section, a "hospital-based physician" is a physician who individually enrolls in the medicaid program, provides services to individual patients in the hospital, and is either a salaried employee of the hospital or through an agreement with the hospital receives compensation in cash or in kind from or through the hospital. "Compensation" includes an arrangement in which the physician is paid by the hospital through a set amount of compensation or the physician recovers a percentage or part of the hospital collections. A "hospital-based physician" includes:

(1) a physician who is an employee of the hospital providing services to patient in the hospital,

(2) a physician who receives a salary, a portion of collections, fringe benefits, or deferred compensation from the hospital,

(3) a physician whose malpractice insurance, continuing medical costs, or 30 percent or more of on-going professional business costs is paid for by the hospital, or

(4) a physician who receives payment from patients, and returns all or a portion of the payments received from patients to the hospital. (Eff. 10/21/92, Register 124)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 43.110. SURGICAL ASSISTANTS. (a) The division will, in its discretion, pay for physicians acting as surgical assistants. A second surgical assistant will be paid at the same rate as the first surgical assistant when the bill is accompanied by an explanation from the surgeon of the need for the second assistant.

(b) The division will pay physicians acting as surgical assistants the lowest of the actual, usual, or 25 percent of the prevailing charge as determined according to 7 AAC 43.101 and 7 AAC 43.103.

(c) Interns, residents in training, and physician assistants do not qualify for payment for services they render apart from the payment made to a physician. (Eff. 8/18/79, Register 71; am 11/18/93, Register 128)

Authority: AS 47.05.010
AS 47.07.050

~~assistant will be paid at the same rate as the first surgical assistant when the bill is accompanied by an explanation from the surgeon of the need for the second assistant.~~

~~(b) Interns, residents in training, and physician assistants do not qualify for payment for services they render apart from the payment made to a physician. (Eff. 8/18/79, Register 71)~~

~~Authority: AS 47.05.010 AS 47.07.050~~

7 AAC 43.115. LIMITATIONS. (a) The division will make payment to physicians on a fee-for-service basis, subject to the following exceptions and restrictions:

(1) a physical examination is authorized only for beneficiaries when given as a screening under the EPSDT program or for a division-requested examination for the purpose of determining eligibility;

(2) immunizations are authorized only when provided as part of the EPSDT program or when not otherwise available through local public health programs;

(3) when covered services of a consultant or specialist are necessary, approval need not be obtained from the division; a fee for consultation may not be paid when the specialist subsequently performs surgery or renders treatment for which a flat fee or fee-for-service accrues;

(4) on initial and subsequent visits for the purpose of establishing a diagnosis and when services of a specialist or consultant are required, payment will be limited to not more than two such services per diagnosis; any additional specialist or consultant requests must be justified by the attending physician and approved by the division;

(5) payment is not available for nonemergency inpatient hospital services unless the services have been authorized as appropriate by the division before admission to the hospital; failure to obtain authorization will result in nonpayment regardless of the eligibility of the recipient or the appropriateness of the services.

(b) Except as provided in this subsection, the division will not pay for more than one physician visit in a 30-day period for a patient in either a skilled nursing or an intermediate care facility. The division will, in its discretion, pay for additional visits if written justification, acceptable to the division, accompanies the bill for the physician visit. (Eff. 8/18/79, Register 71; am 3/25/83, Register 85; am 7/1/85, Register 95; am 9/25/85, Register 95)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

7 AAC 43.120. X-RAY SERVICES. Diagnostic and follow-up X-rays do not require prior approval by the division, but films must

be made available to the division on request. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

7 AAC 43.125. LABORATORY SERVICES. (a) A physician using his or her own laboratory to provide necessary laboratory services will be reimbursed according to the medicare fee schedule in 42 C.F.R. 405.515.

(b) A physician using the services of an independent laboratory shall request services for a recipient in the same manner that services are requested for a private patient.

(c) An independent laboratory certified by the department, or certified by the state medicaid agency or medicare if located out-of-state, may bill the division directly. Reimbursement for clinical laboratory tests will be made by the division according to the medicare fee schedule in 42 C.F.R. 405.515. (Eff. 8/18/79, Register 71; am 3/30/88, Register 106)

Authority: AS 47.05.010 AS 47.07.050

7 AAC 43.130. PSYCHIATRIC SERVICES. Repealed 5/5/93.

7 AAC 43.131. MENTAL HEALTH SERVICES. (a) Except as provided in (b) of this section and in accordance with 7 AAC 43.725 — 7 AAC 43.729, the division will reimburse an enrolled physician for medically necessary mental health services only if those services are rendered directly by the physician. Mental health services rendered by someone other than the physician must be provided in accordance with 7 AAC 43.725 — 7 AAC 43.729 to be eligible for reimbursement by the division.

(b) Unless the physician is a psychiatrist, the division will not reimburse a physician for mental health services provided in a licensed and medicaid-certified psychiatric hospital or facility, a general acute care hospital as defined in 7 AAC 12.100, a long term care facility as defined in 7 AAC 43.709, or an intermediate care facility for the mentally retarded.

(c) The division will not reimburse a physician for experimental therapy, nonmedically-oriented outpatient therapy, or nonmedically-oriented counseling, including telephone consultation, preparation of reports, narcosynthesis, socialization, recreation therapy, primal therapy, marathon group therapy, megavitamin therapy, pastoral counseling, employment counseling, or explaining an examination to a family member or other responsible person that is provided outside of a family therapy session.

(d) Reimbursement for mental health services will be made only if those services are specified in a treatment plan that meets the requirements of 7 AAC 43.728. (Eff. 5/5/93, Register 126)

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.050
AS 47.07.030

7 AAC 43.135. STERILIZATION. (a) For medicaid coverage of sterilization for family planning purposes, informed consent by the recipient is required before the sterilization is performed. Physicians must use the division's Informed Consent for Sterilization forms available from regional offices or the central office of the division. Other forms will not be accepted.

(b) The waiting period between consent and sterilization must be at least 30 days and not more than 180 days. A waiver of the 30-day waiting period may be granted in cases of premature delivery and emergency abdominal surgery.

(c) Consent may not be obtained from anyone in labor of childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.

(d) Interpreters must be provided where there are language barriers, and special arrangements must be made for handicapped individuals.

(e) Hysterectomies performed for sterilization purposes are not covered under medicaid. Hysterectomies are covered, however, when performed for medical reasons. Recipients must be advised orally and in writing that sterility will result in order for the operation to be covered under medicaid.

(f) Sterilization for individuals institutionalized in correctional facilities or inpatient psychiatric facilities will not be covered under medicaid.

(g) As a condition of receiving payment for sterilization for family planning purposes, a signed, division-approved informed consent form must be attached to the invoice of the provider seeking reimbursement. Failure to submit this form will result in the sterilization not being covered by the division.

(h) Recipients who have been determined by a court to be incompetent or who are under age 21 may not receive medicaid coverage for sterilization. (Eff. 8/18/79, Register 71)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.050

7 AAC 43.140. ABORTIONS. (a) Payment for an abortion will, in the department's discretion, be covered under medicaid if the physician services invoice is accompanied by certification that the life of